

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal authorities must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 1 4 2 6 7 REG. NO.		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Georgia L. Adams				5-16-83		1:10 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Negro		Sept. 30, 1918		64		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 24 HRS	
Lyons, Georgia		U.S.A.				Tolbot		MD	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13b. KIND OF BUSINESS OR INDUSTRY		14. OWN HOME	
Easton		Memorial Hospital at Easton		Housewife		Own Home			
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		16a. STATE		16b. COUNTY		16c. CITY OR TOWN		16d. INSIDE CITY LIMITS?	
Maryland		Caroline		Preston		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17a. STREET ADDRESS	
17. FATHER'S NAME		17. MOTHER'S MAIDEN NAME		18a. STREET ADDRESS		18b. BOX NO.		18c. CITY OR TOWN	
John Everett		Minnie Mae Dixon		Rt. 2, Box 87A		21655			
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		19b. SOCIAL SECURITY NO.		20. INFORMANT		20a. ADDRESS		20b. CITY OR TOWN	
No		218-24-4540		Mrs. Betty Wise		Federalburg, Md.		Laurel Grove Acres, Apt. 2A	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		22. PART I. DEATH WAS CAUSED BY		23. IMMEDIATE CAUSE (a)		23b. DUE TO, OR AS A CONSEQUENCE OF		23c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1590		HEMORRHOGE		DUE TO, OR AS A CONSEQUENCE OF		CANCER OF BOWEL		4 HOURS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		RADIATION THERAPY		3 YEARS	
		(c)						3 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		CANCER OF VAGINA DIAGNOSED JANUARY 1983							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20c. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1980		CANCER OF BOWEL		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION		21e. CITY OR TOWN	
		HOUR A.M. MONTH DAY YEAR				STREET		COUNTY STATE	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that (I) this hospital attended the deceased from		JANUARY 19 83, to MAY 16 19 83, that (I) last saw the deceased alive on		5-16 19 83, and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) two (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
						John A. Hawkinson MD		5-16-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE		22h. CITY OR TOWN	
John A. HAWKINSON		11 EARLE AVE EASTON, MD 21601		MAY 23 1983		John J. Conner		FEDERALSBURG	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. CITY OR TOWN	
Burial		May 20 1983		Federal Hill Cemetery		Federalburg, Caroline, Md.			
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. CITY OR TOWN		24d. STATE	
Frank Tom-Hawkins		Box 43		FEDERALSBURG					

BP _____

HOSPITAL-ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 25M
(VRA 15, 4) 1/79

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8314268 REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) Mary Helen Ashby		2a DATE OF DEATH MONTH DAY YEAR May 20, 1983		2b. HOUR 9:50A.M.	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR DEC. 5 1896	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
10 CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian - The Pines		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY IRS			
13a STATE Md.		13b COUNTY Talbot		13c CITY OR TOWN St. Michaels	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Ashby		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Liza Jane Pryor		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No	
16b SOCIAL SECURITY NO 187-36-8545		17 INFORMANT Doris Collins Cordova, Md.			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 4370 DUE TO, OR AS A CONSEQUENCE OF (b): DUE TO, OR AS A CONSEQUENCE OF (c):					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (1) the deceased attended the hospital from June 19 77 to May 19 83, that (1) we last saw the deceased alive on May 19 83, and that in my opinion death occurred on the date and hour and from the causes stated above.					
22b SIGNATURE R. Lane Wroth, M.D.		22c DEGREE M.D.		22d DATE SIGNED 5-23-83	
22e PHYSICIAN'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.		22f ADDRESS St. Michaels, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5-24-83		23c NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	
23d LOCATION CITY OR TOWN COUNTY STATE Ashton Twsp Delaware PA.					
24 FUNERAL DIRECTOR NAME Newnam Funeral Home		24b ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAY 25 1983	
25b. REGISTRAR'S SIGNATURE John J. Connelley					

3

10/10/10

10/10/10

10/10/10

10/10/10

[Faint, illegible handwriting]

[Faint, illegible handwriting]

[Faint, illegible handwriting]

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 14269	
1. DECEASED NAME (TYPE OR PRINT) Charles C Ayers			2a. DATE OF DEATH MONTH DAY YEAR 5 10 83		2b. HOUR 9:08 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR OCT. 6 1907	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner	12b. KIND OF BUSINESS OR INDUSTRY Restaurant	
13a. STATE Md.		13b. COUNTY Talbot	13c. CITY OR TOWN Easton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 630 Howard St. 21601
14. FATHER'S NAME FIRST MIDDLE LAST Aaron Barton Ayers		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret E. Mulligan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 222-05-7847		17. INFORMANT ADDRESS Paul B. Ayers Easton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) Abdominal sepsis DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Colon (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James C. Gieske, M.D.				22c. DATE SIGNED 5/11/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Gieske, M.D.				22e. ADDRESS 505 Dutchman's Lane Easton, MD 21601	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-13-83	23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.		DATE REC'D. BY REGISTRAR MAY 13 1983	

BP

UNITED STATES
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

100-100000

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [illegible]
RE: [illegible]

[illegible text block]

Very truly yours,
[illegible signature]
Special Agent in Charge

MAY 13 1963
JAMES EARL RAY

(10)

(5)

CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 3 1 4 2 7 0 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marion Beenick					2a. DATE OF DEATH MONTH DAY YEAR 5-8-83			2b. HOUR 8 35 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 23 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF ADMITTED IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Federsburg		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS Concord R.F.D. Fed, Md. 21632	
14. FATHER'S NAME FIRST MIDDLE LAST Walters Nichols					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Margaret Skipton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 181-10-8331		17. INFORMANT ADDRESS Elmer Hasting Hurlock, Md. 21643		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Retropertitoneal leiomyosarcoma 1580 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Uncertain									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: none									
19a. DATE OF OPERATION 5-2-83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 18 (a)			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-20 , 19 83 , to 5-8 , 19 83 , that (I) (we) lost saw the deceased alive on 5-8 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert W. Trever, M.D.						DEGREE M.D.		22c. DATE SIGNED 5-8-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Trever, M.D.						22e. ADDRESS RD3 Box 297 Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-11-83		23c. NAME OF CEMETERY OR CREMATORY Concord Cemetery		23d. LOCATION (CITY OR TOWN) Fed. Caroline Md. 21632		
24. FUNERAL DIRECTOR Williamson Funeral Home						25a. DATE REC'D. BY REGISTRAR MAY 20 1983			

RECEIVED
FEB 11 1963

Memorandum

TO : Mr. Tolson

FROM : Mr. Nichols

DATE: 2-11-63

SUBJECT: [Illegible]

Reference is made to a letter from Mr. Tolson dated 2-11-63.

Enclosed for Mr. Tolson are two copies of a letterhead memorandum dated 2-11-63.

Very truly yours,
Mr. Nichols

101-10-8331 [Illegible] Bureau, No. 101-10-8331

Enclosure

Robert W. Traver, N.D.

2-11-63

Concord Cemetery

Bureau

Enclosure

MED EXAMINER NOTIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

83 14271
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		61	
JAMES W BLAKE		5 25 83		12 P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
male	Blk	MONTH DAY YEAR	76	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md		USA		TALBOT MD	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
EASTON	EASTON MEMORIAL HOSP.		Laborer		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md		Talbot	Easton	201 Federal St. Apt 46	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Perry Blake		Millie Gibson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		—		Walter Blake	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLUS					
1519 } DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF STOMACH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5/16/83		CARCINOMA OF STOMACH		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Harold E. Bauer MD		MD		5.26.83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
HAROLD E. BAUER		MEM HOSPITAL EASTON MD			
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
		5/28/83		Richardson	
		23d. LOCATION CITY OR TOWN		COUNTY STATE	
		Easton		TA Md	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lump H Woodard Easton Md		JUN 9 1983		John J. Carver	

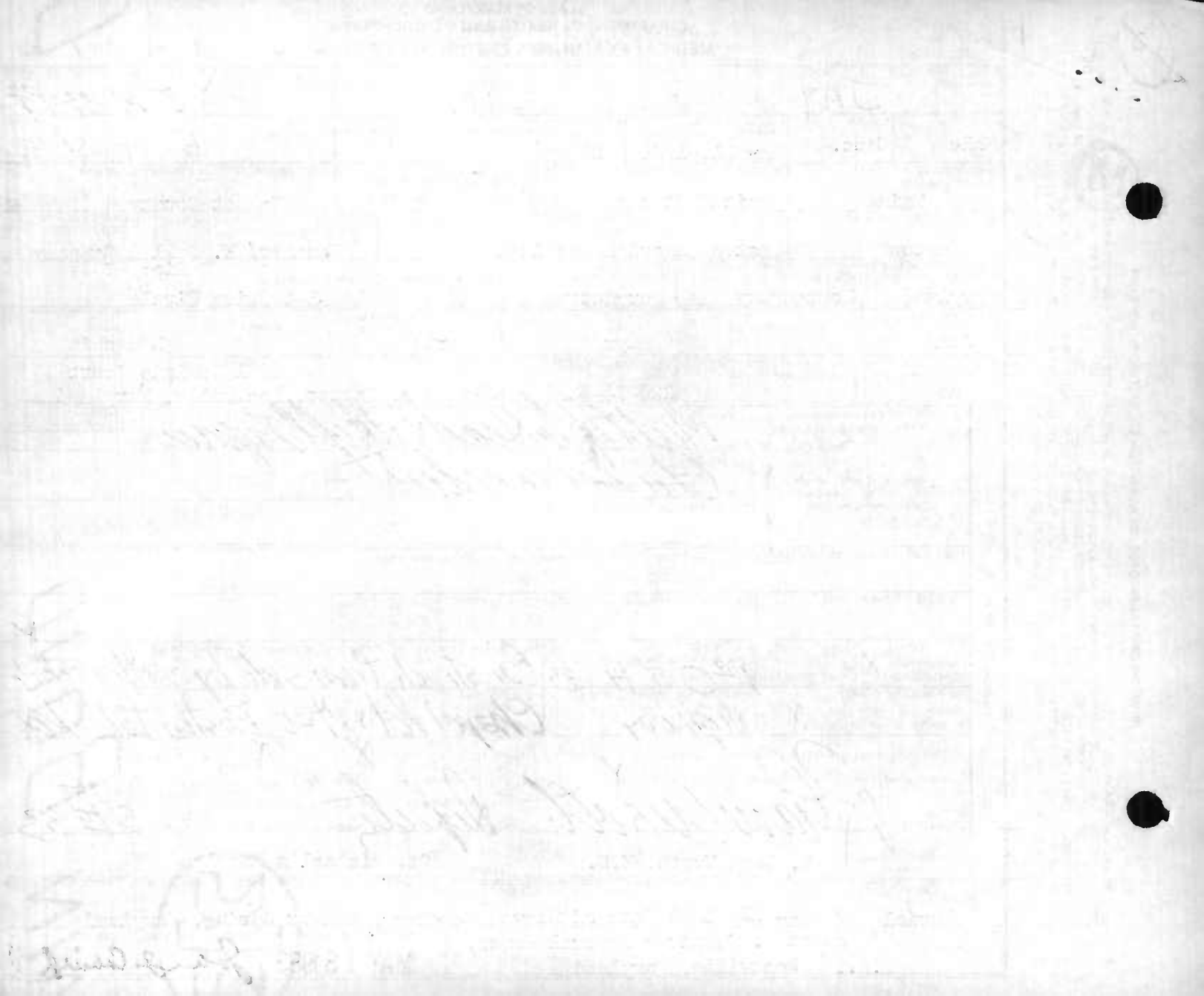
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 2 7 2

1. DECEASED NAME (TYPE OR PRINT)		FIRST JAY		MIDDLE P		LAST CYR		2a. DATE KNOWN OF ESTI- MATED		MONTH 5		DAY 14		YEAR 1983		2b. HOUR 9:32	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR May 31, 1958		6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 5 14 1983		2d. HOUR 9:33	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County MD.											
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager/ W. Bell & Company Zip: 20874						12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 18231-2 Swiss Circle											
14. FATHER'S NAME FIRST MIDDLE LAST Jean Cyr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Langeuin		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No													
17. SOCIAL SECURITY NO. 220-74-8254		17. INFORMANT Jean Cyr, Father, Rockville, Maryland															
18. CAUSE OF DEATH (Enter only one cause per item 18a, 18b, or 18c.) PART I DEATH WAS CAUSED BY: 8129 IMMEDIATE CAUSE (a) Multiple Head & Skull Fractures DUE TO, OR AS A CONSEQUENCE OF Chloroform (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:20 P.M. 5 14 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Car struck from side by another vehicle									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway				21f. LOCATION Chapel Rd & Rt 50, Easton, Talb. Md.									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE R. Lane Wroth, M.D.				MEDICAL EXAMINER St. Michael's Maryland													
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 18, 1983				23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 18 1983				25b. REGISTRAR'S SIGNATURE John J. Conner									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 4 2 7 3
1. DECEASED NAME (TYPE OR PRINT) JEANNE V. CYR												20. DATE KNOWN OF DEATH MATED 5 14 1983
3 SEX Female	4 RACE Cauc.	5 DATE OF BIRTH MONTH DAY YEAR July 29, 1958	6 AGE (IN YEARS) LAST BIRTHDAY 24 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	21. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 14 1983	2d HOUR 10:30 PM	9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County, MD.				
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager		12b. KIND OF BUSINESS OR INDUSTRY Computers				
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Manager		12b. KIND OF BUSINESS OR INDUSTRY Computers				
13a. STATE Maryland												13b. COUNTY Montgomery
13c. CITY OR TOWN Germantown												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET ADDRESS 18231-2 Swiss Circle												Zip: 20874
14. FATHER'S NAME FIRST MIDDLE LAST H. Eugene Violette						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Tyers						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-74-8254						
17. INFORMANT ADDRESS Mr. & Mrs. H. Eugene Violette, Parents 3105 Verona Court, Silver Spring, MD.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8129 IMMEDIATE CAUSE (a) Trauma Neck Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Multiple injuries (c) Auto Accident												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 14 1983						
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1, OR PART 2) Car Struck From Side by another vehicle						21d. LOCATION (STREET, CITY OR TOWN, COUNTY) Chapel Rd & Rt 50, Easton, Tal. Co.						
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>						21f. FACTORS (FALL, ETC.) None						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE R. Lane Wroth						M.D. Deputy MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.						ADDRESS St. Michael's Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE May 18, 1983						
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery						23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland						
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland						25a. DATE REC'D BY REGISTRAR MAY 18 1983						
25b. REGISTRAR'S SIGNATURE John J. [Signature]												

James G. Thompson

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT) George W. Defibaugh						2a. DATE KNOWN OF DEATH ESTIMATED MAY 4 1983 <small>MONTH DAY YEAR</small>	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH <small>MONTH DAY YEAR</small> APRIL 6 1908	6. AGE IN YEARS <small>(LAST BIRTHDAY)</small> 75 RS.	7. IF UNDER 1 YR. <small>MONTHS DAYS HOURS MIN.</small>	8. IF UNDER 24 HRS. <small>MONTHS DAYS HOURS MIN.</small>	2c. DATE PRONOUNCED DEAD 5 4 83 <small>MONTH DAY YEAR</small>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small> Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER	
10. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						12b. KIND OF BUSINESS OR INDUSTRY FARMING	
13a. STATE MARYLAND	13b. COUNTY TALBOT	13c. CITY OR TOWN CLAIBORNE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RICH NECK MANOR 21624	
14. FATHER'S NAME <small>FIRST MIDDLE LAST</small> AUGUSTUS S. DEFIBAUGH				15. MOTHER'S MAIDEN NAME <small>FIRST MIDDLE LAST</small> EFFIE KAGARISE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-14-4812		17. INFORMANT ADDRESS PAUL A. DEFIBAUGH HAMILTON SQUARE NEW JERSEY			
18. CAUSE OF DEATH (Enter only one cause per item 18 part I or II) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) } Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUETO, OR AS A CONSEQUENCE OF } Cerebral Myocardial Infarction Coronary Artery Disease Generalized Atherosclerosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 ()							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY <small>HOUR A.M. MONTH DAY YEAR</small> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (<small>AT HOME, STREET, FACTORY, FARM, ETC.</small>)		21f. LOCATION <small>STREET CITY OR TOWN COUNTY STATE</small>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE R. Gene White		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED 5-6-83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE MAY 7, 1983		23c. NAME OF CEMETERY OR CREMATORY OLIVET CEMETERY		23d. LOCATION <small>CITY OR TOWN COUNTY STATE</small> ST. MICHAELS TALBOT Md.	
74 FUNERAL DIRECTOR <small>NAME ADDRESS</small> Harlan E. Leonard St. Michaels, Md.		25a. DATE REC'D. BY REGISTRAR MAY 11 1983					

27 0001 0 11974 2211W 54A

• A.B.U. • • 2000 •

512-41-015

0000 0000 0000 0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 2 7 5 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kenneth ARTHUR Depew				May 31 83 11 PM			
3. SEX M		4. RACE W		5. DATE OF BIRTH DEC 10 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67	
7a. BIRTHPLACE (STATE OR FOREIGN) N. Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING HOURS) CARP. + PLUMBER		12b. KIND OF BUSINESS OR INDUSTRY BLDG.	
13a. STATE MD		13b. CITY OR TOWN DENTON		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS Rt 1 Box 217	
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR DEPEW		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL HALL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 216-12-1426		17. INFORMANT Hallet F. Depew				ADDRESS Rt 1 Box 217	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) adenocarcinoma of colon DUE TO, OR AS A CONSEQUENCE OF (b) metastatic lesions to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) liver, lungs, + frontal lobe of brain							APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH 3/81
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE 81 5/31 19 83	
22a. I certify that (I) (this hospital) attended the deceased from 5/31 19 83, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.							
22b. SIGNATURE Albert T. Dawkins Jr.				22c. DATE SIGNED 5/1/83		22d. ADDRESS EASTON MARYLAND 21601	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/5/83		23c. NAME OF CEMETERY OR CREMATORY DBLMARIA CRYM.		23d. LOCATION CITY OR TOWN COUNTY STATE KENES DEL.	
24. FUNERAL DIRECTOR NAME ADDRESS MOORE FUNERAL HOME DENTON, Md.				25a. DATE REC'D. BY REGISTRAR JUN 8 1983			
				25b. REGISTRAR'S SIGNATURE John R. Canfield			

BP

Handwritten notes on lined paper, including the words "ARTWORK", "DESK", and "PAPER".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		83		14276		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) William Thomas Elliott				2a. DATE OF DEATH MAY 12 1983		2b. HOUR 2:05a.m.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MAR. 5 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Center-The Pines				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 228 N. Aurora St 21601	
14. FATHER'S NAME William Masten Elliott				15. MOTHER'S MAIDEN NAME Delia McNicholas					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-16-3396		17. INFORMANT ADDRESS William T. Elliott, Jr. Easton, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STROKE</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>MANY YRS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>DIABETES MELLITUS</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>1-8, 1975</u> , to <u>5-12, 1983</u> , that (I) (we) lost saw the deceased alive on <u>4-12, 1983</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen P. Carney</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5-13-83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.				22e. ADDRESS Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-14-83		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot Md			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAY 16 1983			
25b. REGISTRAR'S SIGNATURE <u>John J. Carney</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		83 14277 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
JANE		S.		ERICKSON				MAY 5 1983		5A ^M	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
F		W		05 27 17		65 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Mass.		USA				TALBOT				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
EASTON		Memorial Hospital		Sales		Real Estate					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		21663	
Maryland		Talbot		St. Michaels		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		110 E. Chew Avenue			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Franklin H. Stenberg		Julie Estes									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		271-50-9338		Herbert J. Erickson		110 E. Chew Ave.					
		-----				St. Michaels, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5188		Respiratory Arrest		Chronic Lung Disease		years					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET							
22a. I certify that (a) (this hospital) attended the deceased from above, (b) (we) (did not) view the body after death		19 83 to 5-5 83		19 83		that (b) (we) lost					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
Thomas W. Fautleroy Jr.		MD		5-5-83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Thomas W. Fautleroy Jr.		139 S. WASHINGTON ST		EASTON Md 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
Cremation		May 6, 1983		Ft. Lincoln Cem.		Brentwood		P.G. Maryland			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Harmon B. Leonard		MAY 11 1983		John J. Connel							

MEDICAL CERTIFICATION

110 E. Chew Avenue
St. Michaels, Md.
Sales
Real Estate

110 E. Chew Avenue
St. Michaels, Md.
Sales
Real Estate

110 E. Chew Avenue
St. Michaels, Md.
Sales
Real Estate

110 E. Chew Avenue
St. Michaels, Md.
Sales
Real Estate

110 E. Chew Avenue
St. Michaels, Md.
Sales
Real Estate

110 E. Chew Avenue
St. Michaels, Md.
Sales
Real Estate

110 E. Chew Avenue
St. Michaels, Md.
Sales
Real Estate

110 E. Chew Avenue
St. Michaels, Md.
Sales
Real Estate

110 E. Chew Avenue
St. Michaels, Md.
Sales
Real Estate

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 1 4 2 7 8 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST NORA Ferguson		2a. DATE OF DEATH MONTH DAY YEAR MAY 14, 1983		2b. HOUR 11:55 PM			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 07 02 1896		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 309 West End Ave. 21613	
14. FATHER'S NAME FIRST MIDDLE LAST Jerome Bowles		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie unk.		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 231-30-9617		17. INFORMANT ADDRESS Roy Ferguson Item #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4449 IMMEDIATE CAUSE (a) Suspected embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H W Friedel		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-15-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H W. Friedel		22e. ADDRESS 29 Creamery Lane Easton							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 5/17/1983		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem Park Cambridge Dor. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME John J. Jones 700 Forest St. Cambridge, MD 21613		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 23 1983		25b. REGISTRAR'S SIGNATURE John J. Jones			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 2 7 9 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sarah Bonwill Focht				May 24 1983 12:25A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR FEB 18 1894		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Meridian Nursing Center The Pines		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Denton		13d. STREET ADDRESS Main St. 21629	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Willis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Flora M. Nichols			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO 170-22-0822			
17. INFORMANT Philip E. Nuttle, Jr.				ADDRESS Denton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1: DEATH WAS CAUSED BY: 1639 IMMEDIATE CAUSE (a) <i>Heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of Colon</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>months</i>							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Extensive & Calcific Schizophrenia</i>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) the hospital attended the deceased from Feb 1983 to 24 May 1983, that (1) (Yes) last saw the deceased alive on 21 May 1983 and that in (my) own opinion death occurred on the date and hour and from the causes stated above; and (2) I did not view the body after death.							
22b. SIGNATURE R. Lane Wroth, M.D.				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 5-25-83	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.				22f. ADDRESS St. Michaels, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5-25-83		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del.	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				24b. ADDRESS Easton, Md		25. DATE REC'D. BY REGISTRAR JUN 01 1983	
				26. REGISTRAR'S SIGNATURE			

THESE ARE THE ONLY TWO

[Faint, illegible handwriting]

[Faint, illegible handwriting]

1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 1 4 2 8 0 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) ALVOLYA M FRAZIER					2a. DATE OF DEATH MONTH DAY YEAR MAY 2 1983			2b. HOUR 2:15 P.M.	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR February 2, 1944		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Preston, Md.		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
12. CITY OR TOWN OF DEATH EASTON		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		15. KIND OF BUSINESS OR INDUSTRY Own Home	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland		16b. COUNTY Dorchester		16c. CITY OR TOWN Hurlock		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS Rt. 1, Box 132A-1	
17. FATHER'S NAME FIRST MIDDLE LAST Otis Sharp				18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Jones					
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		19b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1964		19c. SOCIAL SECURITY NO. 214-42-9132		19d. INFORMANT ADDRESS Earl Frazier, Jr., Rt. 1, Box 132A-1, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4290 IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Ventricular Fibrillation					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED 5-4-83			
22a. I certify that (I) (this hospital) attended the deceased from 5-1-83 to 5-2-83 , that (we) lost saw the deceased alive on 5-1-83 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE T.W. Fauntleroy, M.D.		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED 5-4-83			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) T.W. Fauntleroy, M.D.		22f. ADDRESS Easton, Md. 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 6, 1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Preston, Caroline, Maryland			
24. FUNERAL DIRECTOR NAME Frankton-Hendrix Funeral Home		ADDRESS Easton, Md.		25. DATE REC'D. BY REGISTRAR MAY 9 1983					
25. REGISTRAR'S SIGNATURE John J. Carver		25. REGISTRAR'S SIGNATURE John J. Carver							

MEDICAL CERTIFICATION

— 158 —

579-58-MS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 3 1 4 2 8 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ERNEST A. Gadow			2a. DATE OF DEATH MONTH DAY YEAR MAY 26 1983		2b. HOUR 1:08 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 3 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH TA/Port MD.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Farmer		
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		
12b. KIND OF BUSINESS OR INDUSTRY			13a. STREET ADDRESS Main Street 21655		
13a. STATE Maryland			13b. COUNTY Caroline		
13c. CITY OR TOWN Preston			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST August H. Gadow			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agusta Shroder		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a			16b. SOCIAL SECURITY NO. 220-34-9514		
17. INFORMANT Harbert Gadow			ADDRESS Preston, Md. 21655		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) 1979					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: EMPHYSEMA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1980 , 19 5/26/83 , to 5/26/83 , 19 5/26/83 , that (I) (we) last saw the deceased alive on 5/26/83 , 19 5/26/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) saw the body after death.					
22b. SIGNATURE C.R.W. Bain		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/26/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.R.W. BAIN		22e. ADDRESS Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 28,		23c. NAME OF CEMETERY OR CREMATORY Junior Order	
23d. LOCATION CITY OR TOWN COUNTY STATE Preston Car. Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Shaw-Willing - Federalburg, Md.		25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE MAY 31 1983 John J. Caruth			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 83 14282														
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 5-4-83							2b. HOUR 11:40 AM												
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank A Gadow					3. SEX Male					4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 5 1898		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland					7b. CITIZEN OF WHAT COUNTRY? U. S. A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.									
10. CITY OR TOWN OF DEATH Easton					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer					12b. KIND OF BUSINESS OR INDUSTRY Retired									
13a. STATE Maryland					13b. CITY OR TOWN Caroline Preston					13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13d. STREET ADDRESS R. F. D. 21665									
14. FATHER'S NAME FIRST MIDDLE LAST C. Ferdinand Gadow					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna R. Bietz					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) n/a					16b. SOCIAL SECURITY NO. 218-34-9560					17. INFORMANT ADDRESS James Gadow Preston, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumed cardiac arrhythmia 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from 7:6 19 83, to 5:3 19 83, that (I) (we) lost saw the deceased alive on 5:13 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE Michael Crowley MD					DEGREE MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Crowley MD					22e. ADDRESS Easton, MD 21601																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE May 7, 1983					23c. NAME OF CEMETERY OR CREMATORY Junior Order					23d. LOCATION CITY OR TOWN COUNTY STATE Preston Car. Md.									
24. FUNERAL DIRECTOR NAME Edna Williamson ADDRESS Williamson Funeral Home Federal St. Md.										25a. DATE REC'D. BY REGISTRAR MAY 16 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield												

BP

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3		1 4 2 8 3		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MARGARET Stowe GILMORE					2a. DATE OF DEATH MONTH DAY YEAR 5 4 83			2b. HOUR 10 ^P M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR DEC. 29 1898		6. AGE (IN YEARS LAST BIRTHDAY) 84		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13e. STREET ADDRESS Washington St. 21601			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Brown Stowe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Cary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 272-05-4953		17. INFORMANT Ann W. Roberts Northbrook, ILL.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4379 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral vascular insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 5 YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Gastrointestinal hemorrhage									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1970, 19, to 5-4, 1983, that (I) (we) lost saw the deceased alive on 5-4, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stephen P. Carney, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.				22e. ADDRESS Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 5-6-83		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del.			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAY 9 1983		25b. REGISTRAR'S SIGNATURE John J. Carney	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3 1 4 2 8 4 REG. NO.	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT) Charles E Gross				2a. DATE OF DEATH MONTH DAY YEAR 5-2-1983		2b. HOUR / MIN 2 10 M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 12 3 21		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ind	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD		
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY Talbot	13c. CITY OR TOWN Cardova	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Asbury		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Rosie Monroe		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Cardiac arrest Myocardial Infarct days				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 5-2-83		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5-2-83		
22a. I certify that (I) (this hospital) attended the deceased from 8-2-83 to 5-2-83 , that (I) (we) last saw the deceased alive on 8-2-83 , and that (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Informant J.M.D.				22c. DATE SIGNED 5-4-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T.W. Fauntleroy, M.D.				22e. ADDRESS Easton, Md. 21601		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 5/7/83	23c. NAME OF CEMETERY OR CREMATORY Chepot		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD	
24. FUNERAL DIRECTOR NAME ADDRESS George Dashiell Funeral Home Easton, Md. 21601				25a. DATE REC'D. BY REGISTRAR MAY 17 1983		
				REGISTRAR'S SIGNATURE John J. Lamer		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 14285			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JANICE B. HADDAWAY				2b. DATE OF DEATH MONTH DAY YEAR 5-25-83			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 3, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WELDER AIRPAX ELECTRONICS		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY TALBOT		13c. CITY OR TOWN NEAVITT	
14. FATHER'S NAME FIRST MIDDLE LAST PAUL JONES HADDAWAY SR.				15. MOTHER'S MAIDEN NAME CLARA OLIVE JOHNSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS PAUL J. HADDAWAY JR. NEAVITT MARYLAND 21632			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1950 Acute Respiratory Distress							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of the Neck							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Fall 1980, to May 25, 1983, that (I) (we) last saw the deceased alive on May 25, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DR H W Friedel				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-25-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR H W FRIEDEL				22e. ADDRESS 29 Creamery Lane-Easton, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 27, 1983		23c. NAME OF CEMETERY OR CREMATORY NEAVITT CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE NEAVITT TALBOT Md.	
24. FUNERAL DIRECTOR NAME Hanson E Leonard				25a. DATE REC'D. BY REGISTRAR JUN 3 1983			
				25b. REGISTRAR'S SIGNATURE John J. Canick			

1953. 1. 15

1953

1953

U.S.A.

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

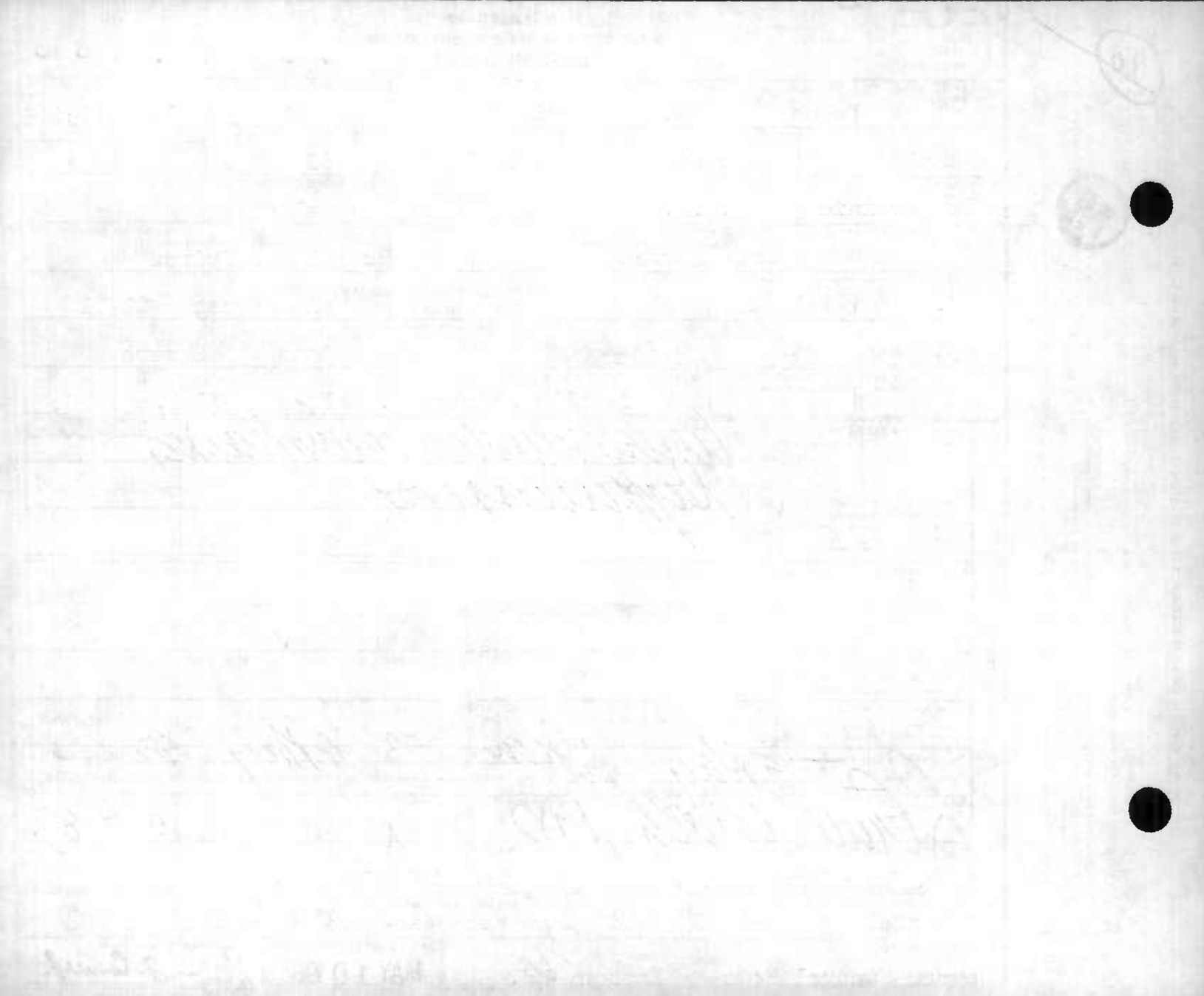
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- STATE REGISTRAR		8314286		REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) Leona G. Harrison				2a DATE OF DEATH MONTH DAY YEAR MAY 6 1983		2b HOUR 11:30 ^P			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR FEB. 20 1898		6 AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7a IF UNDER 1 YEAR MONTHS DAYS 7b IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD			
10 CITY OR TOWN OF DEATH Tilghman		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Main Street				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Bus Driver		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b STREET ADDRESS Main Street 21671			
13a STATE Md.		13b COUNTY Talbot		13c CITY OR TOWN Tilghman					
14 FATHER'S NAME FIRST MIDDLE LAST Lorenzo Dow Hinkle				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Jane Shreve					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-32-0911		17 INFORMANT ADDRESS Shirley G. Walton, Tilghman, Md.					
18 CAUSE OF DEATH (Enter only one cause per item 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4370 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Supertension</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE					
22a I certify that (I) (the hospital attended) the deceased from <i>June 58</i> 19 <i>58</i> , to <i>6 May</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>5/3</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b SIGNATURE <i>R. Lane Wroth, M.D.</i>				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 5-9-83	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b DATE 5-9-83		23c NAME OF CEMETERY OR CREMATORY Tilghman Methodist		23d LOCATION CITY OR TOWN COUNTY STATE Tilghman Talbot Md	
24 FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a DATE REC'D. BY REGISTRAR MAY 10 1983		25b REGISTRAR'S SIGNATURE <i>John J. Conner</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		83		14287		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN.	
Greta S. HUMPLEBY								5 19 83		1205 P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		Jan 16, 1930		53					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maine		USA				Talent MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		Memorial Hospo Easton						waitress-housewife			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		Queen Anne		Grasonville		YES		Box 457 Main St. Grasonville Md. 21638			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Charles Carlson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS				21660			
no		074-24-2965		Mary Ellen Chalupa Rt. #1 Box 133 Ridgley Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 4960										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Myopathies</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>5/19</u> 19 <u>83</u> to <u>5/19</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>5/19</u> 19 <u>83</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Wm H Wood</u>				DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>5/19/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William H. Wood M.D.</u>				22e. ADDRESS <u>Easton Md. 21601</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>5-22-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Prince Georges Co. Suitland Md.</u>					
24. FUNERAL DIRECTOR NAME <u>Helfenbein Funeral Home</u>				ADDRESS <u>Chester, Md.</u>				DATE REC'D BY REGISTRAR <u>John J. Baker</u> REGISTRAR'S SIGNATURE <u>John J. Baker</u> MAY 25 1983			

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IN FILING, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3	REG. NO.	4	2	8	8				
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM JOHN IRWIN, Sr.										ESTIMATED				19				M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR			
Male		Cauca.		May 20, 1891		92 YRS.						5 28 1983		10A		M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				U. S. A.								TALBOT MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
EASTON				MEMORIAL HOSPITAL AT EASTON				Carrier				Postal							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS			
Maryland				Caroline				Denton				YES				First Street 21629			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
William Henry Irwin				Mary Towers															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
No				219428403				NORMAN IRWIN, DENTON, MD. 21629											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) Auricular Fibrillation Left Vent Strain DUE TO, OR AS A CONSEQUENCE OF disease Arteriosclerotic CV disease Coronary Artery yrs DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Arrest sec										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>[Signature]</i>				TITLE (SPECIFY) M.D. <i>[Signature]</i> MEDICAL EXAMINER												DATE SIGNED 6/1/83			
EXAMINER'S NAME (TYPE OR PRINT) Harold B. Plummer M.D.				ADDRESS P.O. box #129 Preston Md 21655															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/1/83				23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Denton Caroline Md.							
24. FUNERAL DIRECTOR NAME Moore Funeral Home, PA. 1212nd St Denton Md.										25a. DATE REC'D. BY REGISTRAR JUN 7 1983								REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3		1 4 2 8 9		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM F. JAYNES				2a. DATE OF DEATH MONTH DAY YEAR 5 - 11-83		2b. HOUR P 6:30 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 1 94		6. AGE (IN YEARS LAST BIRTHDAY) 88		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MERIDIAN NURSING CENTER- THE PINES				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Dorchester 13c. CITY OR TOWN Hurlock				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Charles Street 21643			
14. FATHER'S NAME FIRST MIDDLE LAST William Joseph Jaynes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minerva McKelvey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-26-3652		17. INFORMANT ADDRESS Rt. 4, Box 49 Alyce J. Carey Salisbury, MD 21801					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4920 IMMEDIATE CAUSE (a) Cardio respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema and ASHD young DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Blood Loss, Alzheimer's								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 80 , to 5/11 , 19 83 , that (I) (we) last saw the deceased alive on April , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Phyllis Rhodes		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/16/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. GREGG RHODES, M.D.				22e. ADDRESS 400, Dutchman's Lane, Easton, md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-14-83		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION CITY OR TOWN COUNTY Harrison Ferry, Dor. MD			
24. FUNERAL DIRECTOR Zeller Funeral Home, East New Market, MD				25a. DATE REC'D. BY REGISTRAR MAY 25 1983		25b. REGISTRAR'S SIGNATURE John J. Connel			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH.				83 14290 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN Herman Landon				2a. DATE OF DEATH MONTH DAY YEAR 5-11-83				2b. HOUR 9³⁵ PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 5, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER		12b. KIND OF BUSINESS OR INDUSTRY PRINTING	
13a. STATE MARYLAND				13b. COUNTY TALBOT		13c. CITY OR TOWN SHERWOOD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN TRAVIS LONDON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MALVINA PARKS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 216-07-5214		17. INFORMANT H. RAY LONDON			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ASHD LED hemolytic anemia DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 8 days					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-7 , 19 83 , to 5-11 , 19 83 , that (I) (we) lost saw the deceased alive on 5-11 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Stephen P. Carney				DEGREE M.D.				22c. DATE SIGNED 5-12-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.				22e. ADDRESS Easton, MD 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE MAY 14, 1983		23c. NAME OF CEMETERY OR CREMATORY SHERWOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SHERWOOD TALBOT MARYLAND	
24. FUNERAL DIRECTOR NAME James E. Leland				ADDRESS Dr. Michael M.		25a. DATE REC'D. BY REGISTRAR MAY 17 1983		25b. REGISTRAR'S SIGNATURE John J. Carney	

BP

1957

25 8000 2 20000

• *John F. Kennedy*

• • • • •

Charles E. Jones

NOV 21 1964 4:52 PM - 815

152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 3
REG. NO.

1 4 2 9 1

1. DECEASED NAME (TYPE OR PRINT) Stephen F. Lynch			2a. DATE OF DEATH MONTH DAY YEAR May 12 83			2b. HOUR 24 M			
3 SEX male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 11-9-03		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Tallbot MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Lumber Co.	
13a. STATE Md.			13b. CITY OR TOWN Caroline		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS Central Ave. 21660		
14. FATHER'S NAME FIRST MIDDLE LAST Daniel C. Lynch					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Betchel				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 217-03-5343		17. INFORMANT ADDRESS Pauline Lynch Ridgely, Md.				

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION 5 4/26/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James C. Gieske				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Gieske, M.D.				22e. ADDRESS Easton, MD 21601			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-14-83		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery Greensboro		23d. LOCATION CITY OR TOWN COUNTY STATE Caroline Md.	
24. FUNERAL DIRECTOR NAME ADDRESS John E. Bouda's Greensboro				25a. DATE REC'D. BY REGISTRAR MAY 18 1983			
				25b. REGISTRAR'S SIGNATURE John J. Carver			



Male

Can.

11-8-03

78

nd.

U.S.A.

x

Number Co.

Driver

nd.

Caroline

Ridgely

x

Central Ave.

Daniel C. Lynch

Elizabeth Hotel

no

217-03-2343

Pauline Lynch

Ridgely, Md.

Greenwood Cemetery, Greenboro, N.C.

2-14-83

Greenboro

Burial

2-14-83

John Cross Cemetery, Greenboro, N.C.

John Cross Cemetery, Greenboro, N.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 1 4 2 9 2 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Michael Lyons						2a. DATE OF DEATH MONTH DAY YEAR 5-4-83		2b. HOUR 7:07 ^M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR MAY 5 1983		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 1 5 9		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D. 4, Box 674 21601	
14. FATHER'S NAME FIRST MIDDLE LAST Robin Michael Lyons				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Marie Ball					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Robin M. Lyons Easton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 7651 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Prerenal</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 min.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Hydroamnios, possible fetal malformations</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/4</u> , 19 <u>83</u> , to <u>5/4</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>5/4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard H. Fritz				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/4/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H Fritz MD.				22e. ADDRESS Dutchman's La Easton Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-6-83		23c. NAME OF CEMETERY OR CREMATORY White Marsh Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Trappe Talbot MD			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAY 5 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

7-10-22

124



Eastern General Hospital at Eastern

[Faint, mostly illegible handwritten text follows, appearing to be a medical record or report.]

[Faint, mostly illegible handwritten text at the bottom of the page.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WEST PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3										REG. NO. 4293	
1. DECEASED NAME (TYPE OR PRINT) JAMES A. Mackenzie										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 5 26 1983										2b. HOUR 6:30	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR DEC 9 1919		6. AGE (IN YEARS) (LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 26 1983		24. HOUR 35		24. HOUR 35							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT				MD.					
10. CITY OR TOWN OF DEATH EASTON				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Est. Superintendent				12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																					
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Royal Oak		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Cedar Point		21662											
14. FATHER'S NAME FIRST MIDDLE LAST David MacKenzie					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Watt																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. WW II 1270-20-2787					17. INFORMANT ADDRESS Dixon J. MacKenzie, Royal Oak, Md.											
18. CAUSE OF DEATH (Enter only one cause per PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Superintension (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE R. Lane Wroth					M.D. Deputy					MEDICAL EXAMINER					DATE SIGNED 5-27-83						
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, Md.					ADDRESS St. Michaels, Md.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 5-30-83					23c. NAME OF CEMETERY OR CREMATORY Hazel Green Cemetery					23d. LOCATION CITY OR TOWN COUNTY STATE Hazel Green Wolf KY						
24. FUNERAL DIRECTOR NAME Newnam Funeral Home					ADDRESS Easton, Md.					25a. DATE REC'D. BY REGISTRAR JUN 01 1983					25b. REGISTRAR'S SIGNATURE John J. Carver						

BP

James A. MacKinnon

2 of 214

THAT

James A. MacKinnon

[Faint, illegible handwritten text]

RECEIVED

John J. O'Hara

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83	14294
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH		2b. HOUR	
Bessie Needles		MAY 21, 1983		11:30	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
female	white	June 8, 1906	76	TALBOT MD.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	10. CITY OR TOWN OF DEATH	
Kent Co. Md.	USA	NEVER MARRIED	TALBOT	EASTON	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION	12b. KIND OF BUSINESS OR INDUSTRY	13a. STREET ADDRESS	
MEMORIAL		Housewife		RFD Queen Anne Co. 21620	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
William E. Patrick	Sadie L. Patrick	no			
17. INFORMANT		18. CAUSE OF DEATH			
Betty Watson Chestertown, Md.		PART I. DEATH WAS CAUSED BY: 4408 IMMEDIATE CAUSE (a) <u>Advance arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED			
(IF EITHER, NOTIFY MEDICAL EXAMINER)	HOUR A.M. MONTH DAY YEAR P.M. 19	(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED	21e. PLACE OF INJURY	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and) (not) view the body after death.					
22b. DATE SIGNED		22c. DATE SIGNED			
5/22/83		5/22/83			
22d. ADDRESS		22e. ADDRESS			
Easton, Md. 21601		Easton, Md. 21601			
23a. BURIAL, CREMATION, REINTERMENT	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	5/24/83	Chester Cemetery	Chestertown, Md.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Willis Wells Funeral Home Chestertown, Md.		MAY 27 1983		John J. Carver	

11/11/11 11/11/11 11/11/11

Today

11/11/11

11/11/11

11/11/11 11/11/11 11/11/11

11/11/11 11/11/11 11/11/11

11/11/11 11/11/11 11/11/11

11/11/11 11/11/11 11/11/11

11/11/11 11/11/11 11/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 14295 REG. NO.	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) William STEVENS Orme			2a. DATE OF DEATH MONTH DAY YEAR 5 24 83		2b. HOUR 2:35 P.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 10, 1907	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Tallbot MD.		
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Treasurer		12b. KIND OF BUSINESS OR INDUSTRY Treasury
13a. STATE Maryland		13b. COUNTY Caroline	13c. CITY OR TOWN Denton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Kerr Avenue 21629
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Theodore Orme			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myra Stevens		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220321108	17. INFORMANT ADDRESS Martha Pate, Denton, Maryland 21629		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Respiratory failure days (c) Pneumonia days					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5-20 P3 to 5-24 P3	
22a. I certify that (I) (this hospital) attended the deceased from 5-24-83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas Fauntleroy, M.D.		DEGREE M.D.		22c. DATE SIGNED 5/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas Fauntleroy, M.D.		22e. ADDRESS Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/27/83	23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Denton Caroline Md
24. FUNERAL DIRECTOR NAME Randolph Moore		ADDRESS Denton, Md.		25a. DATED 3 BY REGISTRAR 1983	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8314296

1. DECEASED NAME (TYPE OR PRINT) Sarah Elizabeth Pitts			2a. DATE OF DEATH MONTH DAY YEAR May 5, 1983			2b. HOUR 11:55 AM				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U. S. A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.				
12. CITY OR TOWN OF DEATH Easton		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		15. KIND OF BUSINESS OR INDUSTRY Home		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland			16b. COUNTY Caroline		16c. CITY OR TOWN Denton		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS South Fifth Avenue 21629	
17. FATHER'S NAME FIRST MIDDLE LAST Charles Evans			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Virginia Porter							
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		20. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214033909D		21. INFORMANT ADDRESS Mrs. L. Virginia Barrett, Denton, MD						
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 5070 IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Approximate Interval Between Onset and Death: Hours										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) End Stage Renal Failure ASCA										
23. DATE OF OPERATION 2/7/83			24. CONDITION FOR WHICH OPERATION WAS PERFORMED ASCA			25. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		26. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
30. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			32. LOCATION STREET CITY OR TOWN COUNTY STATE				
33. I certify that (I) (this hospital) attended the deceased from 2/7/83 to 5/5/83, then (I) (we) last saw the deceased alive on 5/5/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.										
34. SIGNATURE Donald T. Lewers, M.D.			35. DEGREE			36. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		37. DATE SIGNED 5/12/83		
38. PHYSICIAN'S NAME (TYPE OR PRINT) Donald T. Lewers, M.D.			39. ADDRESS Dutchmans Lane, Easton, Md. 21601							
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			41. DATE 5/7/83		42. NAME OF CEMETERY OR CREMATORY Denton Cemetery		43. LOCATION CITY OR TOWN COUNTY STATE Denton Caroline Md.			
44. FUNERAL DIRECTOR NAME More Funeral Home 13 S. 2nd St. Denton, Md.			45. ADDRESS		46. DATE REC'D. BY REGISTRAR MAY 17 1983		47. REGISTRAR'S SIGNATURE Ann P. Gault			

BP

U.S. 200

1935

1935

1935

1935

1935

1935

1935



1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

1935

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		83 14297 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST HAZEL		MIDDLE		LAST POTTER		2a. DATE OF DEATH MONTH DAY YEAR 5 30 83	
2b. HOUR 2 05 P.M.		3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 - 11 - 10		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY CA		13c. CITY OR TOWN Goldsboro		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS State Rt. 313, P.O. Box 129 21636	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Gardner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Griffin		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					
16b. SOCIAL SECURITY NO. 092-18-0409		17. INFORMANT ADDRESS Cornelius Potter Goldsboro, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> 5 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/14</u> 19 <u>83</u> , to <u>5/30</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5/30</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Wm A Wood</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>5/30/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Wm A Wood</u>		22e. ADDRESS <u>EASTON, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6-2-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Greensboro CA MD</u>			
24. FUNERAL DIRECTOR NAME <u>Robert E Bowles</u> ADDRESS <u>Greensboro</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 3 1983</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

BP _____

002-18-0409	Cornelius Potter	Goldboro, MD	Griffin	MD	CA	Goldboro	X	State Rt. 313, P.O. Box 133	none	USA	White	9 - 11 - 10	75
002-18-0409	Charles H. Gardner	Margaret	Griffin	MD	CA	Goldboro	X	State Rt. 313, P.O. Box 133	none	USA	White	9 - 11 - 10	75

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 4 2 9 8
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Margaree Price</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5-16-83</i>		2b. HOUR <i>7 40 PM</i>	
3. SEX <i>F.</i>	4. RACE <i>B/K</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11 93</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a. CITY OR TOWN OF DEATH <i>Easton</i>			9b. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i>			
10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>			11a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>		13b. CITY OR TOWN <i>Talbot</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Breeze</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emily Miller</i>		16. SOCIAL SECURITY NO. <i>4860</i>		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		17b. SOCIAL SECURITY NO. <i>4860</i>		17c. INFORMANT <i>Emily Lane</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure 2° to</i> DUE TO, OR AS A CONSEQUENCE OF <i>Chronic lobe pneumonia 1 week</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
--	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.
Ascribed cerebrovascular disease & recent (R) MCA thrombosis

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>411</i>			
21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>5116 411 19 83 to 5116 411 19 83</i>		21g. I certify that (I) (this hospital) attended the deceased from <i>5/16/83</i> to <i>5/16/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)			
22a. SIGNATURE <i>Albert T. Dawkins Jr.</i>		22b. ADDRESS <i>Route 3, Box 127 Easton Maryland 21601</i>		22c. DATE SIGNED <i>5/17/83</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALBERT T. DAWKINS JR.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>5/21/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Richerdon</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Easton Talbot MD</i>	
24. FUNERAL DIRECTOR NAME <i>George Deibel</i>		24b. ADDRESS <i>Easton MD</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 9 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11
9

10. 3. 79
Buck
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200

121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		83		14299		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILLIAM SAWTELLE RATCHFORD				2a. DATE OF DEATH MONTH DAY YEAR May 5, 1983		2b. HOUR M			
3 SEX Male		4 RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR Jan 25, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Talbot County MD.			
10 CITY OR TOWN OF DEATH St. Michaels		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 122 West Chestnut St.,				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supt - Md. Wksp for Blind		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b. CITY OR TOWN Talbot		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 122 W. Chestnut St.			
14 FATHER'S NAME FIRST MIDDLE LAST Charles Banks Ratchford				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Hogan Sawtelle					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-32-0146		17 INFORMANT ADDRESS 122 W. Chestnut St. Michaels,					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured thoracic aortic aneurysm 4411 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (10) ASES									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 9-13 , 19 73 , to 5 May , 19 83 , that (I) (we) lost saw the deceased alive on 5 May , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Stephen P. Carney		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN P. CARNEY, M. D.				22e. ADDRESS Easton, Maryland 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE May 6, 1983		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brantwood P.G. Maryland			
24. FUNERAL DIRECTOR NAME Shirley E. Leonard				25. DATE REC'D. BY REGISTRAR MAY 11 1983					

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH83 14300
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HARRY			2a. DATE OF DEATH MONTH DAY YEAR 5 24 83			2b. HOUR 10:30 PM			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Taichot Co. MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postal Mail Carrier		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Queen Anne		13c. CITY OR TOWN Grasonville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Harry Rimbach		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Younghands				13e. STREET ADDRESS Rt. #1 Box 259 Grasonville Md. 21638			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		(IF YES, GIVE WAR OR DATES) WWII		16b. SOCIAL SECURITY NO. 217-07-9768		17. INFORMANT ADDRESS D. Louise Rimbach Rt. #1 Box 259 Md. 21638			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Uncertain									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Diabetes mellitus with diabetic nephropathy									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 5-29 , 19 82 , to 5-24 , 19 83 , that (1) (we) lost saw the deceased alive on 5-24 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert W. Trever, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-24-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Trever, M.D.						22e. ADDRESS RD 3 Box 297 Easton, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 28, 1983		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Pinkburg Carroll Co. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Helpfenbein Funeral Home Rt. #1 Box 66B Chester Md. 21819						25a. DATE REC'D. BY REGISTRAR JUN 01 1983		25b. REGISTRAR'S SIGNATURE John J. Casper	

BP

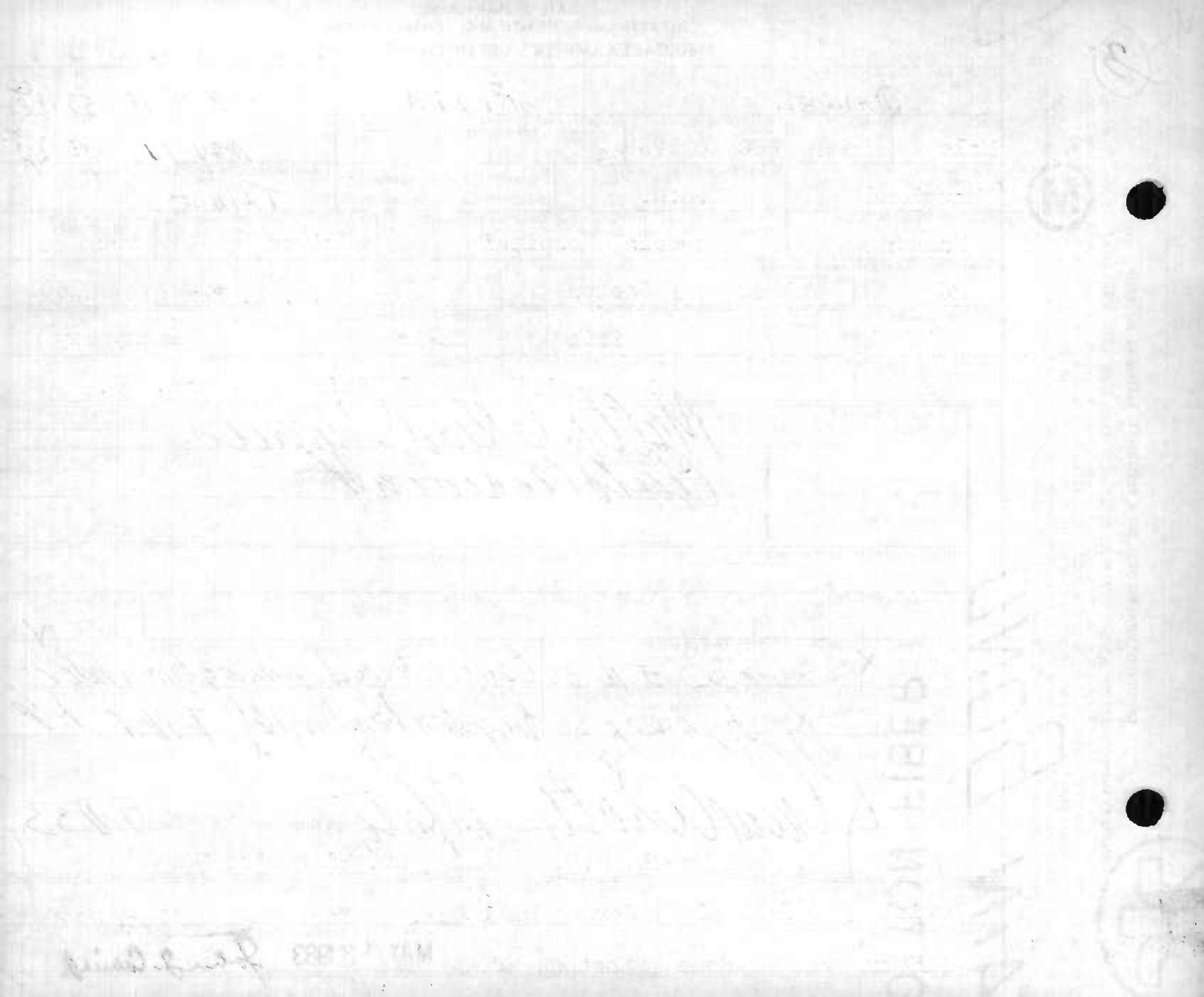
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified or called.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 172 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	4301		
1. DECEASED NAME (TYPE OR PRINT) DANIEL						2a. DATE KNOWN OF DEATH ESTIMATED 5 10 1983						2b. HOUR 11 P			
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR DEC 28 1959		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 23		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MAY 14 1983		2d. HOUR 2 P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Talbot		MD	
11. CITY OR TOWN OF DEATH Easton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Driver				12b. KIND OF BUSINESS OR INDUSTRY Truck			
13a. STATE Md						13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D. 2, Box 472 21601			
14. FATHER'S NAME FIRST MIDDLE LAST Nickola Rizia						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tekla Denczynezy									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 212-82-1154		17. INFORMANT Michael Rizia				ADDRESS Easton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8169 IMMEDIATE CAUSE (a) Multiple Head Injuries DUE TO, OR AS A CONSEQUENCE OF Crash Accident Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Crash Accident DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 5 10 1983						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5 10 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Car overturned pinning him under							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway		21f. LOCATION STREET CITY OR TOWN COUNTY Kingston Landing Rd, Talbot Co							
22a. I certify that I took charge of the remains described above, and an autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE R. Lane Wroth						M.D. Deputy MEDICAL EXAMINER						DATE SIGNED 5-11-83			
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.						ADDRESS St. Michaels, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-13-83		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot Md					
24. FUNERAL DIRECTOR NAME ADDRESS Newnam Funeral Home Easton, Md.						25a. DATE REC'D. BY REGISTRAR MAY 13 1983		25b. REGISTRAR'S SIGNATURE John J. Crick							



MAY 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		83 14302 REG. NO.									
I. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
William						Roberts		5 21 83		11:28 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		BLK		12 10 04		78 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
						TALBOT MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		Easton Memorial Hosp.						Laborer			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
md		TA/BOT		Troppe						Rambert Box 268 21673	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Henry		Roberta		Annice		Howard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
		214-28-2178		Gustine		Roberts					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 4293 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac hypertrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
E. C. H. Schmidt		MD		22d. ADDRESS							
E. C. H. Schmidt				Easton, MD							
23a. BURIAL, CREMATION, REMOVAL (SEE GROUP)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
		5/26/83		paradise		Troppe		TA		md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George Dushell		Easton		JUN 9 1983		John J. Carver					

BP

11. 11. 1900

12. 12. 1900

13. 13. 1900

14. 14. 1900

15. 15. 1900

16. 16. 1900

17. 17. 1900

18. 18. 1900

19. 19. 1900

20. 20. 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examination should be made within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 4 3 0 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) PAUL D ROSSER				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 5 26 83 6⁰⁰ PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 17, 1895		6. AGE (IN YEARS (LAST BIRTHDAY)) 87 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Federalsburg, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Rosser		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Dalious		16. SOCIAL SECURITY NO. 217-36-0709			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-36-0709		17. INFORMANT Louise E. Rosser, Rt. 2, Box 307, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) OBSTRUCTIVE UROPATHY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CANCER PROSTATE, BKR UNRESECTED DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 wk							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1978 , 19____, to 5-26 , 19 83 , that (I) (we) last saw the deceased alive on 5-26 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Stephen P. Carney</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-27-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.		22e. ADDRESS Easton, Md. 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 29, 1983		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Federalsburg, Caroline, Md.	
24. FUNERAL DIRECTOR NAME FRAMPTON-HAWKINS		ADDRESS Box #3 FEDERALSBURG		25a. DATE REC'D. BY REGISTRAR JUN 1 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Carney</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR Item 21a&22a film 580				STATE OF MARYLAND	
1- STATE REGISTRAR 18a 6-15-83 cn				DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
CERTIFICATE OF DEATH				8 3 1 4 3 0 4	
1. DECEASED NAME				2a. DATE OF DEATH	
FIRST MIDDLE LAST				MONTH DAY YEAR	
Melvin Schnappinger				May 24, 1983	
3. SEX		4. RACE		5. DATE OF BIRTH	
male		white		MONTH DAY YEAR	
				Aug 12, 1916	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. AGE (IN YEARS LAST BIRTHDAY)	
Maryland		USA		66 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
EASTON		Easton MEMORIAL Hospital		TALBOT MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
sales		retail			
13a. STREET ADDRESS		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	
11 Knightsbridge Drive		Hyde Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21601					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
George Schnappinger		Eva Siebold			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes		216-09-0637		Mrs. Anna Schnappinger 11 Knightsbridge Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4100				+8 hr, 6 hr	
DUE TO, OR AS A CONSEQUENCE OF (b) ASHTD					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Fractured @ hip Progressive subarachnoid fibrosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY	
5/6/83		Fractured @ hip		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. DATE OF OPERATION		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		2 P.M. 5 3 1983		Fell at home	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
WHITE <input type="checkbox"/> AT WORK NOT WHITE <input checked="" type="checkbox"/> AT WORK		Home		11 Knightsbridge Dr Easton Talbot Md	
22a. I certify that (I) (this hospital) attended the deceased from 5/23/83 to 5/24/83, and that (I) (we) last saw the deceased alive on 5/23/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Wm H Wood		MD		5/24/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Wm H Wood		F EASTON MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
burial		5/26/83		Loudon Park Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Baltimore City Maryland		MAY 25 1983		John J. Conner	
24. FUNERAL DIRECTOR NAME ADDRESS					
Ambrose Funeral Home 1328 Sulphur Spring Rd.					

11

11

Cell C534A:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Margaret A. Schultz								5-24-83		9		45				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Female		Caucasian		JAN. 10 ^Y 1909		74		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										MD.	
Pennsylvania		U.S.A.				TALBOT											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Easton		Memorial Hospital		Housewife													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Talbot		St. Michaels		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		116 W. Chestnut St.								21663	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
John		Carroll		Callahan		Adelia		Ann								Flesk	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS											
No		218-50-1105		John W. Schultz		R.D. 5, Box 713										Easton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4338		Occlusion @ middle Cerebral Artery															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		Cerebral Arteriosclerosis													
		(c)		DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:				Aspiration Pneumonia													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from		83		19		83		to		5/24		19		83		that (I) (we) lost	
saw the deceased alive on		5/24		19		83		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED											
Wm H. Wood Jr		MD				5/25/83											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
Wm H. Wood Jr		EASTON MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		5-27-83		Spring Hill		Easton		Talbot		Md							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Newnam's Funeral Home		Easton, Md. 21601		JUN 01 1983		John J. Casper											

BP

2-14-64

Handwritten signature

Handwritten signature

THAT

Handwritten signature



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must certify the cause of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		83		14306		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Elizabeth C. Stevens				2a. DATE OF DEATH MONTH DAY YEAR MAY 15 1983				2b. HOUR 1:45PM	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR JULY 20 1902		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10 CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Meridian Center-The Pines				12a. USUAL OCCUPATION (LEVEL OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Talbot		13c. CITY OR TOWN Trappe		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Christopher C. Cooper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Denny					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-44-2186		17. INFORMANT ADDRESS A. Thomas Stevens, Jr. Trappe, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Lung Dis DUE TO, OR AS A CONSEQUENCE OF (c) YOUNG								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 19 80 to May 15 19 83, that (I) (we) lost saw the deceased alive on May 18 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE P. Gregg Rhodes, M.D.				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/16/83	
23b. PHYSICIAN'S NAME (TYPE OR PRINT)				22b. ADDRESS Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-18-83		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot Md			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home				ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR MAY 18 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	



Chowder (restorative) from the floor
Backpack for the

Franklin
May 13 1983
Office

MAY 18 1983
Franklin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		Isabel J. STOKES		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		83 14307		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
Isabel		Stokes		5 28 83		5 ²⁰ P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS	
female		white		March 7, 1898		85 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Maryland		USA				Talcot			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial		Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Md.		Kent		Betterton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rural 21609	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
Richard Sterling JONES		Harriett VANCOURT RINGGOLD		no		Paul C. Stokes Beverly Farm St. Michael's			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4140		Arteriosclerotic Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		Generalized Arteriosclerosis				year	
		(c)		Generalized Arteriosclerosis					
				Bronchopneumonia					
PART 2. OTHER SIGNIFICANT DISEASES CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)		Chronic Brain Syndrome		Bronchopneumonia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from May 13, 1983, to May 28, 1983, that (I) (we) last saw the deceased alive on May 13, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		R.F. Manegold				5/31/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
R.F. Manegold, M.D.		Easton, Md. 21601		Burial		June 1, 1983		Chester Cemetery	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Willis Wells Funeral Home		Chestertown, Md.		JUN 6 1983		John J. Connel			

General Hospital, New York

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones



Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

Dr. J. H. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 14303 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MOZELLE SULLIVAN				2a. DATE OF DEATH MONTH DAY YEAR 5 22 83				2b. HOUR 9⁰⁴ A M		
3. SEX Female		4. RACE B/K		5. DATE OF BIRTH MONTH DAY YEAR 2 27 66		6. AGE (IN YEARS LAST BIRTHDAY) 17		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.				
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL @ EASTON				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD				13b. COUNTY G.A.		13c. CITY OR TOWN Chesler		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John - Grant				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabel				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		
17. SOCIAL SECURITY NO. 213-22 4898				18. INFORMANT Isabel				19. ADDRESS Healey		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) and aortic stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate year										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Sept 9 19 82 to May 22 19 83 , that (I) (we) last saw the deceased alive on May 22 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE Willard F. Smith MD						22c. DATE SIGNED 5/23/83		22d. DEGREE MD		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Willard F. Smith						22f. ADDRESS RD # 3, Box 99A, Centerville, Md.				
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE)			23b. DATE 5/28/83			23c. NAME OF CEMETERY OR CREMATORY Rolling Green			23d. LOCATION CITY OR TOWN COUNTY STATE Chesler PA	
24. FUNERAL DIRECTOR NAME George Daskiel						24b. ADDRESS Easton MD		25a. DATE REC'D. BY REGISTRAR JUN 9 1983		
25b. REGISTRAR'S SIGNATURE John L. Cahill										

BP _____

450 22 50 0

1/10/1911

11.5.11

27 0 77

1/10/11

Memorandum for the Hon. Secy of State

(1911)

22 10 18

27 0 77

1/10/11

1/10/11

1/10/11

1/10/11

1/10/11

1/10/11

Proposed amendments to the
Bill for the purpose of
amending the law
relating to the
administration of the
land revenue in the
provinces of the
United Kingdom.

2/10/11

2/10/11

2/10/11

2/10/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH83 14309
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William C. Summers			2a. DATE OF DEATH MONTH DAY YEAR MAY 17 1983			2b. HOUR 6:25 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 10, 1909		6. AGE (IN YEARS, LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Grasonville, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Plastics Co.	
13a. STATE Maryland			13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Harry S. Sommers			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Davis			16. STREET ADDRESS 142 Liberty Road 21632			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 215-01-1011		17. INFORMANT ADDRESS Delaware 19956 William C. Sommers, 777 Millsboro Rd., Laurel				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4120 IMMEDIATE CAUSE (a) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) OLD MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS UNKNOWN									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES - GALLSTONES									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/25/83, 19, to 5/17/83, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did, did not) view the body after death.									
22b. SIGNATURE C.R.W. Bain						DEGREE M.D.		22c. DATE SIGNED 5/17/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.R.W. BAIN						22e. ADDRESS Easton, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE May 20, 1983		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Federalsburg, Caroline, Md.		
24. FUNERAL DIRECTOR NAME Franklin Hawkin Federalsburg Md						25a. DATE REC'D. BY REGISTRAR MAY 23 1983		25b. REGISTRAR'S SIGNATURE John J. Smith	

BP



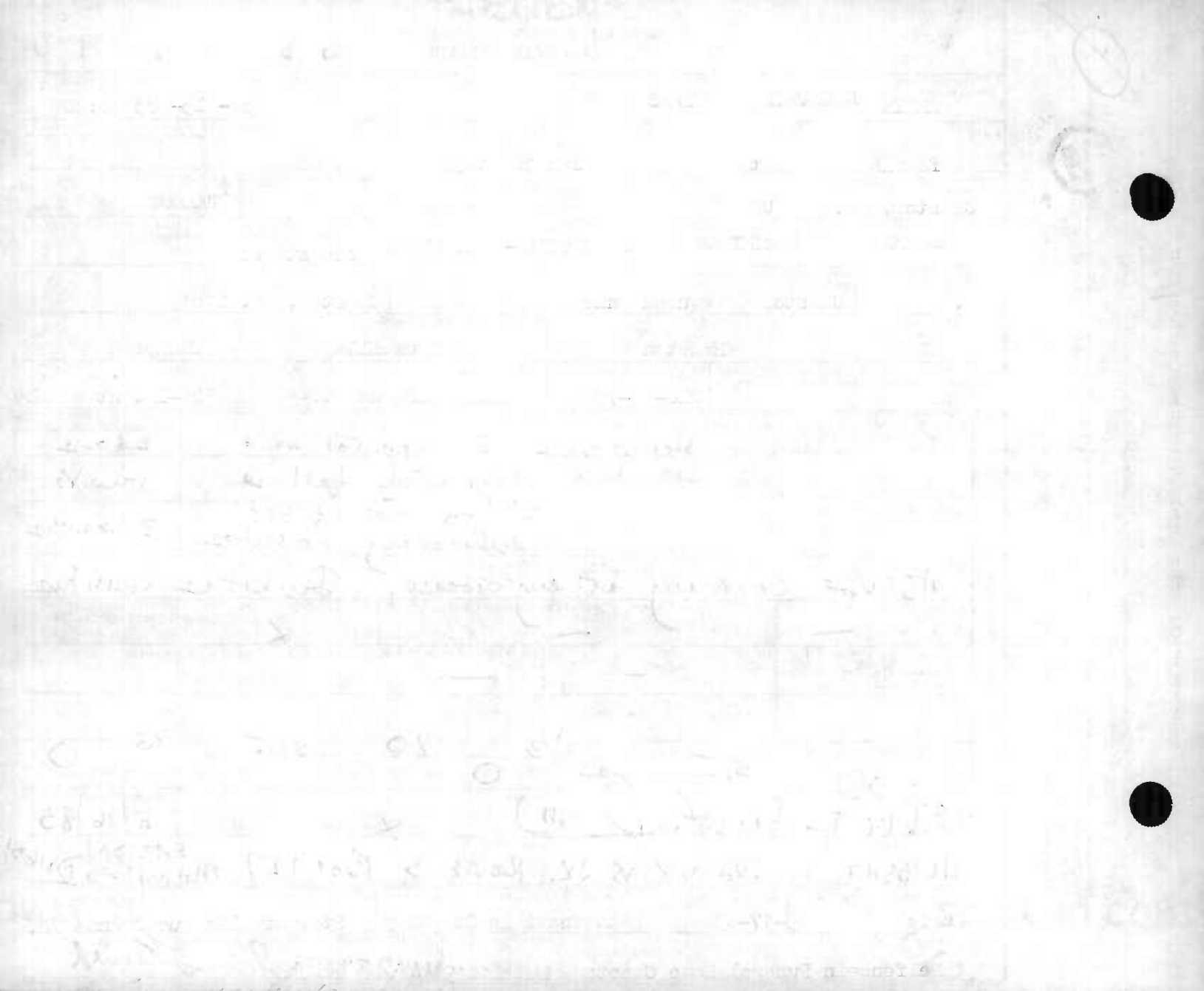
Handwritten notes and text, mostly illegible due to blurriness and bleed-through. Visible fragments include:

- Top left: "W. H. ..."
- Top center: "white ..."
- Top right: "M. ..."
- Middle left: "Liberty ..."
- Middle center: "Liberty ..."
- Middle right: "Liberty ..."
- Bottom left: "Liberty ..."
- Bottom center: "Liberty ..."
- Bottom right: "Liberty ..."

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) ANNIE ELIZABETH TIMMS					2a DATE OF DEATH MONTH DAY YEAR 5 - 15 - 83			2b HOUR A 6:20 M	
3 SEX female		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Jan 18, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chester, Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10 CITY OR TOWN OF DEATH EASTON		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MERIDIAN NURSING CENTER - THE PINES				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) seamstress		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b CITY OR TOWN Chester 13c CITY OR TOWN Queen Anne					13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Chester, Md. 21619		
14 FATHER'S NAME FIRST MIDDLE LAST Olga Hampton					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Druscilla Thompson				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-16-7598		17 INFORMANT ADDRESS Md. 21617 Minnie McShane Rt. #1 Box 326-I Centreville					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1629 Hemiplegia & aspiration +</u> DUE TO, OR AS A CONSEQUENCE OF <u>respiratory failure</u> (b) <u>20 to not astatic</u> DUE TO, OR AS A CONSEQUENCE OF <u>pulmonary nodules</u> (c) <u>?</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 hour</u> <u>? months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>ASIDE coronary artery disease, Diabetes mellitus</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>12/3</u> 19 <u>80</u> to <u>5/15</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>5/15</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b SIGNATURE <u>Albert T. Dawkins Jr.</u>				DEGREE <u>M.D.</u>				22c DATE SIGNED <u>5/16/83</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT T. DAWKINS JR.				22e ADDRESS ROUTE 3 Box 127 EASTON Maryland 21601					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5-17-83		23c NAME OF CEMETERY OR CREMATORY Stevensville Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Stevensville Queen Anne Md.			
24 FUNERAL DIRECTOR NAME Helfenbein Funeral Home				ADDRESS Chester, Md. 21619		25a DATE REC'D. BY REGISTRAR MAY 23 1983			
25b REGISTRAR'S SIGNATURE <u>John J. Connel</u>									



1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3

REG. NO.

1 4 3 1 1

1. DECEASED NAME (TYPE OR PRINT) Tommie Townsend		2a. DATE OF DEATH MONTH DAY YEAR 5-29-83		2b. HOUR 1p M
3. SEX MALE	4. RACE NEGROE	5. DATE OF BIRTH MONTH DAY YEAR AUG. 16, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA U.S.A.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARETAKER MARTINGHAM	
13a. STATE MARYLAND		13b. COUNTY TALBOT	13c. CITY OR TOWN WITTMAN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SADIE TOWNSEND		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 239-16-7134		17. INFORMANT P.O. BOX 112 GRACE GREENWITTMAN, MARYLAND 21676

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

1629
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **giant cell ca of LVL lung**

DUE TO, OR AS A CONSEQUENCE OF

(c) **metastatic disease to RVL**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Ext to (B) + (L) brain

19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —	21f. LOCATION STREET CITY OR TOWN COUNTY STATE —	
22a. I certify that (I) (this hospital) attended the deceased from 4/16 19 83 , to 5/29 19 83 , that (I) (we) last saw the deceased alive on 5/29 19 83 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Albert T. Dawkins Jr. M.D.	DEGREE M	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/29/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT T. DAWKINS JR. M.D.		22e. ADDRESS Box 127 Easton Maryland 21601	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE MAXX JUNE 1, 1983	23c. NAME OF CEMETERY OR CREMATORY THOMAS MEMORIAL ST. MICHAELS TALBOT Md	23d. LOCATION CITY OR TOWN COUNTY STATE —
24. FUNERAL DIRECTOR NAME Edmund A. Michaels Inc.		25a. DATE REC'D. BY REGISTRAR JUN 3 1983	25b. REGISTRAR'S SIGNATURE Joan L. Carver

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1010

1010

NO 0801 20 200A

100000

100000

100000 100000

100000 100000

100000 100000

100000 100000

100000 100000

100000 100000

100000 100000

100000 100000 100000 100000 100000 100000

100000

100000 100000 100000 100000 100000 100000

100000 100000 100000 100000 100000 100000

100000 100000 100000 100000 100000 100000

100000

100000 100000 100000 100000 100000 100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 3 1 4 3 1 2
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Nellie D. Welsh		5-22-83		10 ¹⁰ AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	Caucasian	MONTH DAY YEAR OCT. 3 1918	64 YRS.	Talbot MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Talbot		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Easton	Memorial Hospital		Beautician		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Md.	Talbot	Easton	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		21601	
FIRST MIDDLE LAST Edward George Dietert		FIRST MIDDLE LAST Elva Irene Spies		523 Goldsborough St.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		213-01-8147		PO Box 36 Peggy J. Garner Newcomb, Md. 21653	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u>					
1991 DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>with bowel obstruction</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Stanley M. Bysshe</u>		MD			
22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22b. ADDRESS			
Stanley M. Bysshe, Jr., M.D.		Easton, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	5-25-83	Spring Hill	Easton Talbot Md		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Newnam Funeral Home		Easton, Md.	MAY 25 1983		

10-23

TO:

Mr. Tolson

Mr. Boardman

Dear Sir:

RECEIVED
JAN 10 1951

RECEIVED
JAN 10 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 14313 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) <i>Willie Dennis West Sr.</i>			
3. SEX <i>Male</i>				2a. DATE OF DEATH MONTH <i>5</i> DAY <i>5</i> YEAR <i>83</i> 2b. HOUR <i>10:52</i> AM			
4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH <i>2</i> DAY <i>23</i> YEAR <i>14</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> IF UNDER 1 YEAR HOURS <i></i> MIN. <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Richwood, W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Easton Memorial</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Truck Driver</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Spector Freight</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Greensboro</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <i>Arthur</i> MIDDLE <i>West</i> LAST <i></i>		15. MOTHER'S MAIDEN NAME FIRST <i>Katie</i> MIDDLE <i></i> LAST <i></i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-05-0007</i>	
17. INFORMANT <i>Leroy West</i>		17. ADDRESS <i>4810 Richard Ave., 21214</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe Chronic Obstructive Pulmonary Disease</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Asthmatic - Bronchitis</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Severe Atherosclerotic Cardiovascular Disease</i>							
19a. DATE OF OPERATION <i>NONE</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NONE</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. <i></i> MONTH <i></i> DAY <i>19</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <i></i> CITY OR TOWN <i></i> COUNTY <i></i> STATE <i></i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/14</i> , 19 <i>82</i> , to <i>5/51</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>5/51</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Samuel Quentin Bricker MD</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>5/7/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SAMUEL QUENTIN BRICKER, MD</i>				22e. ADDRESS <i>P.O. Box 122 Goldsboro, Md 21629</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5/9/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greensboro Cem. Assoc.</i>		23d. LOCATION CITY OR TOWN <i>Greensboro</i> COUNTY <i>Md.</i> STATE <i></i>	
24. <i>Schimmek Funeral Home, Inc.</i> 3331 Brehms Lane, Balto., Md. 21213				25a. DATE REC'D. BY REGISTRAR <i>MAY 13 1983</i>		25b. REGISTRAR'S SIGNATURE <i>Samuel Bricker</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3	REG. NO. 1 4 3 1 4								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Howard Herman Zendt										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5 21 19 83		2b. HOUR MIN 12 25							
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 04 26 40		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 43		IF UNDER 1 YR. MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 21 19 83		7d. HOUR MIN 12 25					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TAILOT				MD.					
10. CITY OR TOWN OF DEATH Near ST. MICHAEL				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON MEM HOSPITAL - DOA				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN				12b. KIND OF BUSINESS OR INDUSTRY RUBBER							
13a. STATE MARYLAND				13b. COUNTY ALLEGANY				13c. CITY OR TOWN CUMBERLAND				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Route 5 Box 335 NN 21502							
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES H. ZENDT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH HOUTZ															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 161 32 8258				17. INFORMANT ADDRESS MRS. PEG W. ZENDT - same as above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8160 IMMEDIATE CAUSE (a) Brawl Skull Fracture Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Multiple Head Injuries (c) Cerebral Hemorrhage														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 11 23 AM 5 21 19 83				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) lost control of car on curve											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (STREET, FACILITY, FARM, ETC.) private road				21f. LOCATION (CITY OR TOWN, COUNTY, STATE) Martinsburg Md. Telbot Co. Md.											
22a. I certify that the charges of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE R. Paul Wroth				M.D. (SPECIFY) MD				MEDICAL EXAMINER EASTON, MARYLAND				DATE SIGNED 5-21-83							
EXAMINER'S NAME (TYPE OR PRINT) R. PAUL WROTH				ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 05 24 83				23c. NAME OF CEMETERY OR CREMATORY WESTMINSTER PRESBY.				23d. LOCATION (CITY OR TOWN, COUNTY, STATE) MIFKINTOWN, JUNIATA, PA.							
24. FUNERAL DIRECTOR NAME JOHN J. HAFFER, JR.								ADDRESS LA VALE, MD				25a. DATE REC'D. BY REGISTRAR JUN 6 1983				25b. REGISTRAR'S SIGNATURE John J. Hafler			

Handwritten text at the top of the page, including the word "THAT" and other illegible markings.

Handwritten text in the middle section, featuring the word "THAT" and other illegible markings.

Handwritten text in the lower middle section, featuring the word "THAT" and other illegible markings.

Handwritten text in the lower section, featuring the word "THAT" and other illegible markings.

Handwritten text at the bottom of the page, featuring the word "THAT" and other illegible markings.